

107TH CONGRESS
1ST SESSION

S. 1545

To amend title XVIII of the Social Security Act to provide regulatory relief and contracting flexibility under the Medicare Program.

IN THE SENATE OF THE UNITED STATES

OCTOBER 15, 2001

Mr. INHOFE introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

To amend title XVIII of the Social Security Act to provide regulatory relief and contracting flexibility under the Medicare Program.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SECU-**
4 **RITY ACT; TABLE OF CONTENTS.**

5 (a) SHORT TITLE.—This Act may be cited as the
6 “Medicare Regulatory and Contracting Reform Act of
7 2001”.

8 (b) AMENDMENTS TO SOCIAL SECURITY ACT.—Ex-
9 cept as otherwise specifically provided, whenever in this
10 Act an amendment is expressed in terms of an amendment

1 to or repeal of a section or other provision, the reference
 2 shall be considered to be made to that section or other
 3 provision of the Social Security Act.

4 (c) TABLE OF CONTENTS.—The table of contents of
 5 this Act is as follows:

- Sec. 1. Short title; amendments to Social Security Act; table of contents.
- Sec. 2. Issuance of regulations.
- Sec. 3. Compliance with changes in regulations and policies.
- Sec. 4. Increased flexibility in medicare administration.
- Sec. 5. Provider education and technical assistance.
- Sec. 6. Small provider technical assistance demonstration program.
- Sec. 7. Medicare Provider Ombudsman.
- Sec. 8. Provider appeals.
- Sec. 9. Recovery of overpayments and prepayment review; enrollment of providers.
- Sec. 10. Beneficiary outreach demonstration program.
- Sec. 11. Policy development regarding evaluation and management (E & M) documentation guidelines.

6 (d) CONSTRUCTION.—Nothing in this Act shall be
 7 construed—

8 (1) to compromise or affect existing legal au-
 9 thority for addressing fraud or abuse, whether it be
 10 criminal prosecution, civil enforcement, or adminis-
 11 trative remedies, including under sections 3729
 12 through 3733 of title 31, United States Code
 13 (known as the False Claims Act); or

14 (2) to prevent or impede the Department of
 15 Health and Human Services in any way from its on-
 16 going efforts to eliminate waste, fraud, and abuse in
 17 the medicare program.

18 Furthermore, the consolidation of medicare administrative
 19 contracting set forth in this Act does not constitute con-

1 solidation of the Federal Hospital Insurance Trust Fund
 2 and the Federal Supplementary Medical Insurance Trust
 3 Fund or reflect any position on that issue.

4 **SEC. 2. ISSUANCE OF REGULATIONS.**

5 (a) CONSOLIDATION OF PROMULGATION TO ONCE A
 6 MONTH.—

7 (1) IN GENERAL.—Section 1871 (42 U.S.C.
 8 1395hh) is amended by adding at the end the fol-
 9 lowing new subsection:

10 “(d) The Secretary shall issue proposed or final (in-
 11 cluding interim final) regulations to carry out this title
 12 only on one business day of every month unless publication
 13 on another date is necessary to comply with requirements
 14 under law.”.

15 (2) REPORT ON PUBLICATION OF REGULATIONS
 16 ON A QUARTERLY BASIS.—Not later than 3 years
 17 after the date of the enactment of this Act, the Sec-
 18 retary of Health and Human Services shall submit
 19 to Congress a report on the feasibility of requiring
 20 that regulations described in section 1871(d) of the
 21 Social Security Act only be promulgated on a single
 22 day every calendar quarter.

23 (3) EFFECTIVE DATE.—The amendment made
 24 by paragraph (1) shall apply to regulations promul-

1 gated on or after the date that is 30 days after the
2 date of the enactment of this Act.

3 (b) REGULAR TIMELINE FOR PUBLICATION OF
4 FINAL RULES.—

5 (1) IN GENERAL.—Section 1871(a) (42 U.S.C.
6 1395hh(a)) is amended by adding at the end the fol-
7 lowing new paragraph:

8 “(3) The Secretary, in consultation with the Director
9 of the Office of Management and Budget, shall establish
10 a regular timeline for the publication of final regulations
11 based on the previous publication of a proposed regulation
12 or an interim final regulation. Such timeline may vary
13 among different regulations based on differences in the
14 complexity of the regulation, the number and scope of
15 comments received, and other relevant factors. In the case
16 of interim final regulations, upon the expiration of the reg-
17 ular timeline established under this paragraph for the pub-
18 lication of a final regulation after opportunity for public
19 comment, the interim final regulation shall not continue
20 in effect unless the Secretary publishes a notice of continu-
21 ation of the regulation that includes an explanation of why
22 the regular timeline was not complied with. If such a no-
23 tice is published, the regular timeline for publication of
24 the final regulation shall be treated as having begun again
25 as of the date of publication of the notice.”.

1 (2) EFFECTIVE DATE.—The amendment made
2 by paragraph (1) shall take effect on the date of the
3 enactment of this Act. The Secretary of Health and
4 Human Services shall provide for an appropriation
5 transition to take into account the backlog of pre-
6 viously published interim final regulations.

7 (c) LIMITATIONS ON NEW MATTER IN FINAL REGU-
8 LATIONS.—

9 (1) IN GENERAL.—Section 1871(a) (42 U.S.C.
10 1395hh(a)), as amended by subsection (b), is further
11 amended by adding at the end the following new
12 paragraph:

13 “(4) Insofar as a final regulation (other than
14 an interim final regulation) includes a provision that
15 is not a logical outgrowth of the relevant notice of
16 proposed rulemaking relating to such regulation,
17 that provision shall be treated as a proposed regula-
18 tion and shall not take effect until there is the fur-
19 ther opportunity for public comment and a publica-
20 tion of the provision again as a final regulation.”.

21 (2) EFFECTIVE DATE.—The amendment made
22 by paragraph (1) shall apply to final regulations
23 published on or after the date of the enactment of
24 this Act.

1 **SEC. 3. COMPLIANCE WITH CHANGES IN REGULATIONS**
2 **AND POLICIES.**

3 (a) NO RETROACTIVE APPLICATION OF SUB-
4 STANTIVE CHANGES; TIMELINE FOR COMPLIANCE WITH
5 SUBSTANTIVE CHANGES AFTER NOTICE.—Section 1871
6 (42 U.S.C. 1395hh), as amended by section 2(a), is
7 amended by adding at the end the following new sub-
8 section:

9 “(e)(1)(A) A substantive change in regulations, man-
10 ual instructions, interpretative rules, statements of policy,
11 or guidelines of general applicability under this title shall
12 not be applied (by extrapolation or otherwise) retroactively
13 to items and services furnished before the date the change
14 was issued, unless the Secretary determines that such ret-
15 roactive application would have a positive impact on bene-
16 ficiaries or providers of services, physicians, practitioners,
17 and other suppliers or would be necessary to comply with
18 statutory requirements.

19 “(B) No compliance action shall be made against a
20 provider of services, physician, practitioner, or other sup-
21 plier with respect to noncompliance with such a sub-
22 stantive change for items and services furnished on or be-
23 fore the date that is 30 days after the date of issuance
24 of the change, unless the Secretary provides otherwise.”.

1 (b) RELIANCE ON GUIDANCE.—Section 1871(e), as
2 added by subsection (a), is further amended by adding at
3 the end the following new paragraph:

4 “(2) If—

5 “(A) a provider of services, physician, practi-
6 tioner, or other supplier follows the written guidance
7 provided by the Secretary or by a medicare con-
8 tractor (as defined in section 1889(f)) acting within
9 the scope of the contractor’s contract authority with
10 respect to the furnishing of items or services and
11 submission of a claim for benefits for such items or
12 services;

13 “(B) the Secretary determines that the provider
14 of services, physician, practitioner, or supplier has
15 accurately presented the circumstances relating to
16 such items, services, and claim to the contractor in
17 writing; and

18 “(C) the guidance was in error;
19 the provider of services, physician, practitioner or supplier
20 shall not be subject to any sanction if the provider of serv-
21 ices, physician, practitioner, or supplier reasonably relied
22 on such guidance.”.

1 **SEC. 4. INCREASED FLEXIBILITY IN MEDICARE ADMINIS-**
 2 **TRATION.**

3 (a) CONSOLIDATION AND FLEXIBILITY IN MEDICARE
 4 ADMINISTRATION.—

5 (1) IN GENERAL.—Title XVIII is amended by
 6 inserting after section 1874 the following new sec-
 7 tion:

8 “CONTRACTS WITH MEDICARE ADMINISTRATIVE
 9 CONTRACTORS

10 “SEC. 1874A. (a) AUTHORITY.—

11 “(1) AUTHORITY TO ENTER INTO CON-
 12 TRACTS.—The Secretary may enter into contracts
 13 with any entity to serve as a medicare administrative
 14 contractor with respect to the performance of any or
 15 all of the functions described in paragraph (3) or
 16 parts of those functions (or, to the extent provided
 17 in a contract, to secure performance thereof by other
 18 entities).

19 “(2) MEDICARE ADMINISTRATIVE CONTRACTOR
 20 DEFINED.—For purposes of this title and title XI:

21 “(A) IN GENERAL.—The term ‘medicare
 22 administrative contractor’ means an agency, or-
 23 ganization, or other person with a contract
 24 under this section.

25 “(B) APPROPRIATE MEDICARE ADMINIS-
 26 TRATIVE CONTRACTOR.—With respect to the

1 performance of a particular function or activity
 2 in relation to an individual entitled to benefits
 3 under part A or enrolled under part B, or both,
 4 a specific provider of services, physician, practi-
 5 tioner, or supplier (or class of such providers of
 6 services, physicians, practitioners, or suppliers),
 7 the ‘appropriate’ medicare administrative con-
 8 tractor is the medicare administrative con-
 9 tractor that has a contract under this section
 10 with respect to the performance of that function
 11 or activity in relation to that individual, pro-
 12 vider of services, physician, practitioner, or sup-
 13 plier or class of provider of services, physician,
 14 practitioner, or supplier.

15 “(3) FUNCTIONS DESCRIBED.—The functions
 16 referred to in paragraph (1) are payment functions,
 17 provider services functions, and beneficiary services
 18 functions as follows:

19 “(A) DETERMINATION OF PAYMENT
 20 AMOUNTS.—Determining (subject to the provi-
 21 sions of section 1878 and to such review by the
 22 Secretary as may be provided for by the con-
 23 tracts) the amount of the payments required
 24 pursuant to this title to be made to providers

1 of services, physicians, practitioners, and sup-
2 pliers.

3 “(B) MAKING PAYMENTS.—Making pay-
4 ments described in subparagraph (A).

5 “(C) BENEFICIARY EDUCATION AND AS-
6 SISTANCE.—Serving as a center for, and com-
7 municating to individuals entitled to benefits
8 under part A or enrolled under part B, or both,
9 with respect to education and outreach for
10 those individuals, and assistance with specific
11 issues, concerns or problems of those individ-
12 uals.

13 “(D) PROVIDER CONSULTATIVE SERV-
14 ICES.—Providing consultative services to insti-
15 tutions, agencies, and other persons to enable
16 them to establish and maintain fiscal records
17 necessary for purposes of this title and other-
18 wise to qualify as providers of services, physi-
19 cians, practitioners, or suppliers.

20 “(E) COMMUNICATION WITH PRO-
21 VIDERS.—Serving as a center for, and commu-
22 nicating to providers of services, physicians,
23 practitioners, and suppliers, any information or
24 instructions furnished to the medicare adminis-
25 trative contractor by the Secretary, and serving

1 as a channel of communication from such pro-
2 viders, physicians, practitioners, and suppliers
3 to the Secretary.

4 “(F) PROVIDER EDUCATION AND TECH-
5 NICAL ASSISTANCE.—Performing the functions
6 described in subsections (e) and (f), relating to
7 provider education, training, and technical as-
8 sistance.

9 “(G) ADDITIONAL FUNCTIONS.—Per-
10 forming such other functions as are necessary
11 to carry out the purposes of this title.

12 “(4) RELATIONSHIP TO MIP CONTRACTS.—

13 “(A) NONDUPLICATION OF DUTIES.—In
14 entering into contracts under this section, the
15 Secretary shall assure that functions of medi-
16 care administrative contractors in carrying out
17 activities under parts A and B do not duplicate
18 functions carried out under the Medicare Integ-
19 rity Program under section 1893. The previous
20 sentence shall not apply with respect to the ac-
21 tivity described in section 1893(b)(5) (relating
22 to prior authorization of certain items of dura-
23 ble medical equipment under section
24 1834(a)(15)).

1 “(B) CONSTRUCTION.—An entity shall not
2 be treated as a medicare administrative con-
3 tractor merely by reason of having entered into
4 a contract with the Secretary under section
5 1893.

6 “(b) CONTRACTING REQUIREMENTS.—

7 “(1) USE OF COMPETITIVE PROCEDURES.—

8 “(A) IN GENERAL.—Notwithstanding any
9 law with general applicability to Federal acqui-
10 sition and procurement and except as provided
11 in subparagraph (B), the Secretary shall use
12 competitive procedures when entering into con-
13 tracts with medicare administrative contractors
14 under this section.

15 “(B) RENEWAL OF CONTRACTS.—The Sec-
16 retary may renew a contract with a medicare
17 administrative contractor under this section
18 from term to term without regard to section 5
19 of title 41, United States Code, or any other
20 provision of law requiring competition, if the
21 medicare administrative contractor has met or
22 exceeded the performance requirements applica-
23 ble with respect to the contract and contractor.

24 “(C) TRANSFER OF FUNCTIONS.—Func-
25 tions may be transferred among medicare ad-

1 ministrative contractors in accordance with the
2 provisions of this paragraph. The Secretary
3 shall ensure that performance quality is consid-
4 ered in such transfers.

5 “(D) INCENTIVES FOR QUALITY.—The
6 Secretary shall provide financial incentives and
7 such other incentives as the Secretary deter-
8 mines appropriate for medicare administrative
9 contractors to provide quality service and to
10 promote efficiency.

11 “(2) COMPLIANCE WITH REQUIREMENTS.—No
12 contract under this section shall be entered into with
13 any medicare administrative contractor unless the
14 Secretary finds that such medicare administrative
15 contractor will perform its obligations under the con-
16 tract efficiently and effectively and will meet such
17 requirements as to financial responsibility, legal au-
18 thority, and other matters as the Secretary finds
19 pertinent.

20 “(3) DEVELOPMENT OF SPECIFIC PERFORM-
21 ANCE REQUIREMENTS.—In developing contract per-
22 formance requirements, the Secretary shall develop
23 performance requirements to carry out the specific
24 requirements applicable under this title to a function
25 described in subsection (a)(3).

1 “(4) INFORMATION REQUIREMENTS.—The Sec-
2 retary shall not enter into a contract with a medi-
3 care administrative contractor under this section un-
4 less the contractor agrees—

5 “(A) to furnish to the Secretary such time-
6 ly information and reports as the Secretary may
7 find necessary in performing his functions
8 under this title; and

9 “(B) to maintain such records and afford
10 such access thereto as the Secretary finds nec-
11 essary to assure the correctness and verification
12 of the information and reports under subpara-
13 graph (A) and otherwise to carry out the pur-
14 poses of this title.

15 “(5) SURETY BOND.—A contract with a medi-
16 care administrative contractor under this section
17 may require the medicare administrative contractor,
18 and any of its officers or employees certifying pay-
19 ments or disbursing funds pursuant to the contract,
20 or otherwise participating in carrying out the con-
21 tract, to give surety bond to the United States in
22 such amount as the Secretary may deem appro-
23 priate.

24 “(c) TERMS AND CONDITIONS.—

1 “(1) IN GENERAL.—A contract with any medi-
2 care administrative contractor under this section
3 may contain such terms and conditions as the Sec-
4 retary finds necessary or appropriate and may pro-
5 vide for advances of funds to the medicare adminis-
6 trative contractor for the making of payments by it
7 under subsection (a)(3)(B).

8 “(2) PROHIBITION ON MANDATES FOR CERTAIN
9 DATA COLLECTION.—The Secretary may not require,
10 as a condition of entering into a contract under this
11 section, that the medicare administrative contractor
12 match data obtained other than in its activities
13 under this title with data used in the administration
14 of this title for purposes of identifying situations in
15 which the provisions of section 1862(b) may apply.

16 “(d) LIMITATION ON LIABILITY OF MEDICARE AD-
17 MINISTRATIVE CONTRACTORS AND CERTAIN OFFICERS.—

18 “(1) CERTIFYING OFFICER.—No individual des-
19 ignated pursuant to a contract under this section as
20 a certifying officer shall, in the absence of negligence
21 or intent to defraud the United States, be liable with
22 respect to any payments certified by the individual
23 under this section.

24 “(2) DISBURSING OFFICER.—No disbursing of-
25 ficer shall, in the absence of negligence or intent to

1 defraud the United States, be liable with respect to
 2 any payment by such officer under this section if
 3 it was based upon an authorization (which meets the
 4 applicable requirements for such internal controls es-
 5 tablished by the Comptroller General) of a certifying
 6 officer designated as provided in paragraph (1) of
 7 this subsection.

8 “(3) LIABILITY OF MEDICARE ADMINISTRATIVE
 9 CONTRACTOR.—A medicare administrative con-
 10 tractor shall be liable to the United States for a pay-
 11 ment referred to in paragraph (1) or (2) if, in con-
 12 nection with such payment, an individual referred to
 13 in either such paragraph acted with gross negligence
 14 or intent to defraud the United States.”.

15 (2) CONSIDERATION OF INCORPORATION OF
 16 CURRENT LAW STANDARDS.—In developing contract
 17 performance requirements under section 1874A(b)
 18 of the Social Security Act, as inserted by paragraph
 19 (1), the Secretary of Health and Human Services
 20 shall consider inclusion of the performance stand-
 21 ards described in sections 1816(f)(2) of such Act
 22 (relating to timely processing of reconsiderations and
 23 applications for exemptions) and section
 24 1842(b)(2)(B) of such Act (relating to timely review
 25 of determinations and fair hearing requests), as such

1 sections were in effect before the date of the enact-
 2 ment of this Act.

3 (b) CONFORMING AMENDMENTS TO SECTION 1816
 4 (RELATING TO FISCAL INTERMEDIARIES).—Section 1816
 5 (42 U.S.C. 1395h) is amended as follows:

6 (1) The heading is amended to read as follows:

7 “PROVISIONS RELATING TO THE ADMINISTRATION OF
 8 PART A”.

9 (2) Subsection (a) is amended to read as fol-
 10 lows:

11 “(a) The administration of this part shall be con-
 12 ducted through contracts with medicare administrative
 13 contractors under section 1874A.”.

14 (3) Subsection (b) is repealed.

15 (4) Subsection (c) is amended—

16 (A) by striking paragraph (1); and

17 (B) in each of paragraphs (2)(A) and
 18 (3)(A), by striking “agreement under this sec-
 19 tion” and inserting “contract under section
 20 1874A that provides for making payments
 21 under this part”.

22 (5) Subsections (d) through (i) are repealed.

23 (6) Subsections (j) and (k) are each amended—

24 (A) by striking “An agreement with an
 25 agency or organization under this section” and
 26 inserting “A contract with a medicare adminis-

3 (B) by striking “such agency or organiza-
4 tion” and inserting “such medicare administra-
5 tive contractor” each place it appears.

6 (7) Subsection (1) is repealed.

(c) CONFORMING AMENDMENTS TO SECTION 1842
(RELATING TO CARRIERS).—Section 1842 (42 U.S.C.
1395u) is amended as follows:

10 (1) The heading is amended to read as follows:

11 “PROVISIONS RELATING TO THE ADMINISTRATION OF
12 PART B”.

13 (2) Subsection (a) is amended to read as fol-
14 lows:

15 “(a) The administration of this part shall be con-
16 ducted through contracts with medicare administrative
17 contractors under section 1874A.”.

18 (3) Subsection (b) is amended—

19 (A) by striking paragraph (1);

20 (B) in paragraph (2)—

21 (i) by striking subparagraphs (A) and
22 (B);

(ii) in subparagraph (C), by striking
“carriers” and inserting “medicare admin-
istrative contractors”; and

1 (iii) by striking subparagraphs (D)
 2 and (E);

3 (C) in paragraph (3)—

4 (i) in the matter before subparagraph
 5 (A), by striking “Each such contract shall
 6 provide that the carrier” and inserting
 7 “The Secretary”;

8 (ii) in subparagraph (B), in the mat-
 9 ter before clause (i), by striking “to the
 10 policyholders and subscribers of the car-
 11 rier” and inserting “to the policyholders
 12 and subscribers of the medicare adminis-
 13 trative contractor”;

14 (iii) by striking subparagraphs (C),
 15 (D), and (E);

16 (iv) in subparagraph (H)—

17 (I) by striking “it” and inserting
 18 “the Secretary”; and

19 (II) by striking “carrier” and in-
 20 serting “medicare administrative con-
 21 tractor”; and

22 (v) in the seventh sentence, by insert-
 23 ing “medicare administrative contractor,”
 24 after “carrier,”; and

25 (D) by striking paragraph (5); and

1 (E) in paragraph (7) and succeeding para-
 2 graphs, by striking “the carrier” and inserting
 3 “the Secretary” each place it appears.

4 (4) Subsection (c) is amended—

5 (A) by striking paragraph (1);

6 (B) in paragraph (2), by striking “contract
 7 under this section which provides for the dis-
 8bursement of funds, as described in subsection
 9 (a)(1)(B),” and inserting “contract under sec-
 10 tion 1874A that provides for making payments
 11 under this part shall provide that the medicare
 12 administrative contractor”;

13 (C) in paragraph (4), by striking “a car-
 14rier” and inserting “medicare administrative
 15contractor”;

16 (D) in paragraph (5), by striking “contract
 17 under this section which provides for the dis-
 18bursement of funds, as described in subsection
 19 (a)(1)(B), shall require the carrier” and insert-
 20ing “contract under section 1874A that pro-
 21vides for making payments under this part shall
 22require the medicare administrative con-
 23tractor”; and

24 (E) by striking paragraph (6).

25 (5) Subsections (d), (e), and (f) are repealed.

(6) Subsection (g) is amended by striking “carrier or carriers” and inserting “medicare administrative contractor or contractors”.

(7) Subsection (h) is amended—

(A) in paragraph (2)—

(i) by striking “Each carrier having an agreement with the Secretary under subsection (a)” and inserting “The Secretary”; and

(ii) by striking “Each such carrier” and inserting “The Secretary”; and

(B) in paragraph (3)(A)—

(i) by striking “a carrier having an agreement with the Secretary under subsection (a)” and inserting “medicare administrative contractor having a contract under section 1874A that provides for making payments under this part”; and

(ii) by striking “such carrier” and inserting “such contractor”.

(d) EFFECTIVE DATE; TRANSITION RULE.—

(1) EFFECTIVE DATE.—Except as otherwise provided in this subsection, the amendments made by this section shall take effect on October 1, 2003, and the Secretary of Health and Human Services is

1 authorized to take such steps before such date as
2 may be necessary to implement such amendments on
3 a timely basis.

4 (2) GENERAL TRANSITION RULES.—(A) The
5 Secretary shall take such steps as are necessary to
6 provide for an appropriate transition from contracts
7 under section 1816 and section 1842 of the Social
8 Security Act (42 U.S.C. 1395h, 1395u) to contracts
9 under section 1874A, as added by subsection (a)(1).

10 (B) Any such contract under such sections
11 1816 or 1842 whose periods begin before or during
12 the 1-year period that begins on the first day of the
13 fourth calendar month that begins after the date of
14 enactment of this Act may be entered into without
15 regard to any provision of law requiring the use of
16 competitive procedures.

17 (3) AUTHORIZING CONTINUATION OF MIP
18 FUNCTIONS UNDER CURRENT CONTRACTS AND
19 AGREEMENTS AND UNDER ROLLOVER CONTRACTS.—
20 The provisions contained in the exception in section
21 1893(d)(2) of the Social Security Act (42 U.S.C.
22 1395ddd(d)(2)) shall continue to apply notwith-
23 standing the amendments made by this section, and
24 any reference in such provisions to an agreement or
25 contract shall be deemed to include a contract under

1 section 1874A of such Act, as inserted by subsection
 2 (a)(1), that continues the activities referred to in
 3 such provisions.

4 (e) REFERENCES.—On and after the effective date
 5 provided under subsection (d), any reference to a fiscal
 6 intermediary or carrier under title XI or XVIII of the So-
 7 cial Security Act (or any regulation, manual instruction,
 8 interpretative rule, statement of policy, or guideline issued
 9 to carry out such titles) shall be deemed a reference to
 10 an appropriate medicare administrative contractor (as
 11 provided under section 1874A of the Social Security Act).

12 (f) SECRETARIAL SUBMISSION OF LEGISLATIVE PRO-
 13 POSAL.—Not later than 6 months after the date of the
 14 enactment of this Act, the Secretary of Health and
 15 Human Services shall submit to the appropriate commit-
 16 tees of Congress a legislative proposal providing for such
 17 technical and conforming amendments in the law as are
 18 required by the provisions of this section.

19 **SEC. 5. PROVIDER EDUCATION AND TECHNICAL ASSIST-**
 20 **ANCE.**

21 (a) COORDINATION OF EDUCATION FUNDING.—

22 (1) IN GENERAL.—The Social Security Act is
 23 amended by inserting after section 1888 the fol-
 24 lowing new section:

1 “PROVIDER EDUCATION AND TECHNICAL ASSISTANCE

2 “SEC. 1889. (a) COORDINATION OF EDUCATION
3 FUNDING.—The Secretary shall coordinate the edu-
4 cational activities provided through medicare contractors
5 (as defined in subsection (i), including under section
6 1893) in order to maximize the effectiveness of Federal
7 education efforts for providers of services, physicians,
8 practitioners, and suppliers.”.

9 (2) EFFECTIVE DATE.—The amendment made
10 by paragraph (1) shall take effect on the date of the
11 enactment of this Act.

12 (3) REPORT.—Not later than October 1, 2002,
13 the Secretary of Health and Human Services shall
14 submit to Congress a report that includes a descrip-
15 tion and evaluation of the steps taken to coordinate
16 the funding of provider education under section
17 1889(a) of the Social Security Act, as added by
18 paragraph (1).

19 (b) INCENTIVES TO IMPROVE CONTRACTOR PER-
20 FORMANCE.—

21 (1) IN GENERAL.—Section 1874A, as added by
22 section 4(a)(1), is amended by adding at the end the
23 following new subsection:

24 “(e) INCENTIVES TO IMPROVE CONTRACTOR PER-
25 FORMANCE IN PROVIDER EDUCATION AND OUTREACH.—

1 “(1) METHODOLOGY TO MEASURE CONTRACTOR
2 ERROR RATES.—In order to give medicare adminis-
3 trative contractors an incentive to implement effec-
4 tive education and outreach programs for providers
5 of services, physicians, practitioners, and suppliers,
6 the Secretary shall develop and implement by Octo-
7 ber 1, 2002, a methodology to measure the specific
8 claims payment error rates of such contractors in
9 the processing or reviewing of medicare claims.

10 “(2) IDENTIFICATION OF BEST PRACTICES.—
11 The Secretary shall identify the best practices devel-
12 oped by individual medicare administrative contrac-
13 tors for educating providers of services, physicians,
14 practitioners, and suppliers and how to encourage
15 the use of such best practices nationwide.”.

16 (2) REPORT.—Not later than October 1, 2003,
17 the Secretary of Health and Human Services shall
18 submit to Congress a report that describes how the
19 Secretary intends to use the methodology developed
20 under section 1874A(e)(1) of the Social Security
21 Act, as added by paragraph (1), in assessing medi-
22 care contractor performance in implementing effec-
23 tive education and outreach programs, including
24 whether to use such methodology as the basis for
25 performance bonuses.

1 (c) PROVISION OF ACCESS TO AND PROMPT RE-
 2 SPONSES FROM MEDICARE ADMINISTRATIVE CONTRAC-
 3 TORS.—

4 (1) IN GENERAL.—Section 1874A, as added by
 5 section 4(a)(1) and as amended by subsection (b), is
 6 further amended by adding at the end the following
 7 new subsection:

8 “(f) RESPONSE TO INQUIRIES; TOLL-FREE LINES.—

9 “(1) CONTRACTOR RESPONSIBILITY.—Each
 10 medicare administrative contractor shall, for those
 11 providers of services, physicians, practitioners, and
 12 suppliers which submit claims to the contractor for
 13 claims processing—

14 “(A) respond in a clear, concise, and accu-
 15 rate manner to specific billing and cost report-
 16 ing questions of providers of services, physi-
 17 cians, practitioners, and suppliers;

18 “(B) maintain a toll-free telephone number
 19 at which providers of services, physicians, prac-
 20 titioners, and suppliers may obtain information
 21 regarding billing, coding, and other appropriate
 22 information under this title;

23 “(C) maintain a system for identifying who
 24 provides the information referred to in subpara-
 25 graphs (A) and (B); and

1 “(D) monitor the accuracy, consistency,
2 and timeliness of the information so provided.

3 “(2) EVALUATION.—In conducting evaluations
4 of individual medicare administrative contractors,
5 the Secretary shall take into account the results of
6 the monitoring conducted under paragraph (1)(D).
7 The Secretary shall, in consultation with organiza-
8 tions representing providers of services, physicians,
9 practitioners, and suppliers, establish standards re-
10 lating to the accuracy, consistency, and timeliness of
11 the information so provided.”.

12 (2) EFFECTIVE DATE.—The amendment made
13 by paragraph (1) shall take effect October 1, 2002.

14 (d) IMPROVED PROVIDER EDUCATION AND TRAIN-
15 ING.—

16 (1) IN GENERAL.—Section 1889, as added by
17 subsection (a), is amended by adding at the end the
18 following new subsections:

19 “(b) ENHANCED EDUCATION AND TRAINING.—

20 “(1) ADDITIONAL RESOURCES.—For each of
21 fiscal years 2003 and 2004, there are authorized to
22 be appropriated to the Secretary (in appropriate
23 part from the Federal Hospital Insurance Trust
24 Fund and the Federal Supplementary Medical In-
25 surance Trust Fund) \$10,000,000.

1 “(2) USE.—The funds made available under
 2 paragraph (1) shall be used to increase the conduct
 3 by medicare contractors of education and training of
 4 providers of services, physicians, practitioners, and
 5 suppliers regarding billing, coding, and other appro-
 6 priate items.

7 “(c) TAILORING EDUCATION AND TRAINING ACTIVI-
 8 TIES FOR SMALL PROVIDERS OR SUPPLIERS.—

9 “(1) IN GENERAL.—Insofar as a medicare con-
 10 tractor conducts education and training activities, it
 11 shall tailor such activities to meet the special needs
 12 of small providers of services or suppliers (as defined
 13 in paragraph (2)).

14 “(2) SMALL PROVIDER OF SERVICES OR SUP-
 15 PLIER.—In this subsection, the term ‘small provider
 16 of services or supplier’ means—

17 “(A) an institutional provider of services
 18 with fewer than 25 full-time-equivalent employ-
 19 ees; or

20 “(B) a physician, practitioner, or supplier
 21 with fewer than 10 full-time-equivalent employ-
 22 ees.”.

23 “(2) EFFECTIVE DATE.—The amendment made
 24 by paragraph (1) shall take effect on October 1,
 25 2002.

1 (e) REQUIREMENT TO MAINTAIN INTERNET
2 SITES.—

3 (1) IN GENERAL.—Section 1889, as added by
4 subsection (a) and as amended by subsection (d), is
5 further amended by adding at the end the following
6 new subsection:

7 “(c) INTERNET SITES; FAQs.—The Secretary, and
8 each medicare contractor insofar as it provides services
9 (including claims processing) for providers of services,
10 physicians, practitioners, or suppliers, shall maintain an
11 Internet site which provides answers in an easily accessible
12 format to frequently asked questions relating to providers
13 of services, physicians, practitioners, and suppliers under
14 the programs under this title and title XI insofar as it
15 relates to such programs.”.

16 (2) EFFECTIVE DATE.—The amendment made
17 by paragraph (1) shall take effect on October 1,
18 2002.

19 (f) ADDITIONAL PROVIDER EDUCATION PROVI-
20 SIONS.—

21 (1) IN GENERAL.—Section 1889, as added by
22 subsection (a) and as amended by subsections (d)
23 and (e), is further amended by adding at the end
24 the following new subsections:

1 “(d) ENCOURAGEMENT OF PARTICIPATION IN EDU-
 2 CATION PROGRAM ACTIVITIES.—A medicare contractor
 3 may not use a record of attendance at (or failure to at-
 4 tend) educational activities or other information gathered
 5 during an educational program conducted under this sec-
 6 tion or otherwise by the Secretary to select or track pro-
 7 viders of services, physicians, practitioners, or suppliers
 8 for the purpose of conducting any type of audit or prepay-
 9 ment review.

10 “(e) CONSTRUCTION.—Nothing in this section or sec-
 11 tion 1893(g) shall be construed as providing for disclosure
 12 by a medicare contractor—

13 “(1) of the screens used for identifying claims
 14 that will be subject to medical review; or

15 “(2) of information that would compromise
 16 pending law enforcement activities or reveal findings
 17 of law enforcement-related audits.

18 “(f) DEFINITIONS.—For purposes of this section, the
 19 term ‘medicare contractor’ includes the following:

20 “(1) A medicare administrative contractor with
 21 a contract under section 1874A, including a fiscal
 22 intermediary with a contract under section 1816 and
 23 a carrier with a contract under section 1842.

24 “(2) An eligible entity with a contract under
 25 section 1893.

1 Such term does not include, with respect to activities of
 2 a specific provider of services, physician, practitioner, or
 3 supplier an entity that has no authority under this title
 4 or title IX with respect to such activities and such provider
 5 of services, physician, practitioner, or supplier.”.

6 (2) EFFECTIVE DATE.—The amendment made
 7 by paragraph (1) shall take effect on the date of the
 8 enactment of this Act.

9 **SEC. 6. SMALL PROVIDER TECHNICAL ASSISTANCE DEM-**
 10 **ONSTRATION PROGRAM.**

11 (a) ESTABLISHMENT.—

12 (1) IN GENERAL.—The Secretary of Health and
 13 Human Services shall establish a demonstration pro-
 14 gram (in this section referred to as the “demonstra-
 15 tion program”) under which technical assistance is
 16 made available, upon request on a voluntary basis,
 17 to small providers of services or suppliers to evaluate
 18 their billing and related systems for compliance with
 19 the applicable requirements of the programs under
 20 medicare program under title XVIII of the Social
 21 Security Act (including provisions of title XI of such
 22 Act insofar as they relate to such title and are not
 23 administered by the Office of the Inspector General
 24 of the Department of Health and Human Services).

1 (2) SMALL PROVIDERS OF SERVICES OR SUP-
 2 PLIERS.—In this section, the term “small providers
 3 of services or suppliers” means—

4 (A) an institutional provider of services
 5 with fewer than 25 full-time-equivalent employ-
 6 ees; or

7 (B) a physician, practitioner, or supplier
 8 with fewer than 10 full-time-equivalent employ-
 9 ees.

10 (b) QUALIFICATION OF CONTRACTORS.—In con-
 11 ducting the demonstration program, the Secretary of
 12 Health and Human Services shall enter into contracts
 13 with qualified organizations (such as peer review organiza-
 14 tions or entities described in section 1889(f)(2) of the So-
 15 cial Security Act, as inserted by section 5(f)(1)) with ap-
 16 propriate expertise with billing systems of the full range
 17 of providers of services, physicians, practitioners, and sup-
 18 pliers to provide the technical assistance. In awarding such
 19 contracts, the Secretary shall consider any prior investiga-
 20 tions of the entity’s work by the Inspector General of De-
 21 partment of Health and Human Services or the Comp-
 22 troller General of the United States.

23 (c) DESCRIPTION OF TECHNICAL ASSISTANCE.—The
 24 technical assistance provided under the demonstration
 25 program shall include a direct and in-person examination

1 of billing systems and internal controls of small providers
 2 of services or suppliers to determine program compliance
 3 and to suggest more efficient or effective means of achiev-
 4 ing such compliance.

5 (d) AVOIDANCE OF RECOVERY ACTIONS FOR PROB-
 6 LEMS IDENTIFIED AS CORRECTED.—The Secretary of
 7 Health and Human Services may provide that, absent evi-
 8 dence of fraud and notwithstanding any other provision
 9 of law, any errors found in a compliance review for a small
 10 provider of services or supplier that participates in the
 11 demonstration program shall not be subject to recovery
 12 action if the technical assistance personnel under the pro-
 13 gram determine that—

14 (1) the problem that is the subject of the com-
 15 pliance review has been corrected to their satisfac-
 16 tion within 30 days of the date of the visit by such
 17 personnel to the small provider of services or sup-
 18 plier; and

19 (2) such problem remains corrected for such pe-
 20 riod as is appropriate.

21 (e) GAO EVALUATION.—Not later than 2 years after
 22 the date of the date the demonstration program is first
 23 implemented, the Comptroller General, in consultation
 24 with the Inspector General of the Department of Health
 25 and Human Services, shall conduct an evaluation of the

1 demonstration program. The evaluation shall include a de-
 2 termination of whether claims error rates are reduced for
 3 small providers of services or suppliers who participated
 4 in the program. The Comptroller General shall submit a
 5 report to the Secretary and the Congress on such evalua-
 6 tion and shall include in such report recommendations re-
 7 garding the continuation or extension of the demonstra-
 8 tion program.

9 (f) FINANCIAL PARTICIPATION BY PROVIDERS.—The
 10 provision of technical assistance to a small provider of
 11 services or supplier under the demonstration program is
 12 conditioned upon the small provider of services or supplier
 13 paying for 25 percent of the cost of the technical assist-
 14 ance.

15 (g) AUTHORIZATION OF APPROPRIATIONS.—There
 16 are authorized to be appropriated to the Secretary of
 17 Health and Human Services (in appropriate part from the
 18 Federal Hospital Insurance Trust Fund and the Federal
 19 Supplementary Medical Insurance Trust Fund) to carry
 20 out the demonstration program—

21 (1) for fiscal year 2003, \$1,000,000, and

22 (2) for fiscal year 2004, \$6,000,000.

23 **SEC. 7. MEDICARE PROVIDER OMBUDSMAN.**

24 (a) IN GENERAL.—Section 1868 (42 U.S.C. 1395ee)
 25 is amended—

1 (1) by adding at the end of the heading the fol-
2 lowing: “; MEDICARE PROVIDER OMBUDSMAN”;

3 (2) by inserting “PRACTICING PHYSICIANS AD-
4 VISORY COUNCIL.—(1)” after “(a)”;

5 (3) in paragraph (1), as so redesignated under
6 paragraph (2), by striking “in this section” and in-
7 serting “in this subsection”;

8 (4) by redesignating subsections (b) and (c) as
9 paragraphs (2) and (3), respectively; and

10 (5) by adding at the end the following new sub-
11 section:

12 “(b) MEDICARE PROVIDER OMBUDSMAN.—The Sec-
13 retary shall appoint a Medicare Provider Ombudsman.
14 The Ombudsman shall—

15 “(1) provide assistance, on a confidential basis,
16 to providers of services, physicians, practitioners,
17 and suppliers with respect to complaints, grievances,
18 and requests for information concerning the pro-
19 grams under this title (including provisions of title
20 XI insofar as they relate to this title and are not ad-
21 ministered by the Office of the Inspector General of
22 the Department of Health and Human Services) and
23 in the resolution of unclear or conflicting guidance
24 given by the Secretary and medicare contractors to
25 such providers of services, physicians, practitioners,

1 and suppliers regarding such programs and provi-
 2 sions and requirements under this title and such
 3 provisions; and

4 “(2) submit recommendations to the Secretary
 5 for improvement in the administration of this title
 6 and such provisions, including—

7 “(A) recommendations to respond to recur-
 8 ring patterns of confusion in this title and such
 9 provisions (including recommendations regard-
 10 ing suspending imposition of sanctions where
 11 there is widespread confusion in program ad-
 12 ministration), and

13 “(B) recommendations to provide for an
 14 appropriate and consistent response (including
 15 not providing for audits) in cases of self-identi-
 16 fied overpayments by providers of services, phy-
 17 sicians, practitioners, and suppliers.”.

18 (b) AUTHORIZATION OF APPROPRIATIONS.—There
 19 are authorized to be appropriated to the Secretary of
 20 Health and Human Services (in appropriate part from the
 21 Federal Hospital Insurance Trust Fund and the Federal
 22 Supplementary Medical Insurance Trust Fund) to carry
 23 out the provisions of subsection (b) of section 1868 (relat-
 24 ing to the Medicare Provider Ombudsman), as added by
 25 subsection (a)(5), amounts as follows:

1 (1) For fiscal year 2002, such sums as are nec-
2 essary.

3 (2) For fiscal year 2003, \$8,000,000.

4 (3) For fiscal year 2004, \$17,000,000.

5 (c) REPORT ON ADDITIONAL FUNDING.—Not later
6 than October 1, 2003, the Secretary of Health and
7 Human Services shall submit to Congress a report that
8 includes the Secretary’s estimate of the amount of addi-
9 tional funding necessary to carry out such provisions of
10 subsection (b) of section 1868, as so added, in fiscal year
11 2005 and subsequent fiscal years.

12 **SEC. 8. PROVIDER APPEALS.**

13 (a) MEDICARE ADMINISTRATIVE LAW JUDGES.—
14 Section 1869 (42 U.S.C. 1395ff), as amended by section
15 521(a) of Medicare, Medicaid, and SCHIP Benefits Im-
16 provement and Protection Act of 2000 (114 Stat. 2763A–
17 534), as enacted into law by section 1(a)(6) of Public Law
18 106–554, is amended by adding at the end the following
19 new subsection:

20 “(g) MEDICARE ADMINISTRATIVE LAW JUDGES.—

21 “(1) TRANSITION PLAN.—Not later than Octo-
22 ber 1, 2003, the Commissioner of Social Security
23 and the Secretary shall develop and implement a
24 plan under which administrative law judges respon-
25 sible solely for hearing cases under this title (and re-

lated provisions in title XI) shall be transferred from the responsibility of the Commissioner and the Social Security Administration to the Secretary and the Department of Health and Human Services. The plan shall include recommendations with respect to—

“(A) the number of such administrative law judges and support staff required to hear and decide such cases in a timely manner; and

“(B) funding levels required for fiscal year 2004 and subsequent fiscal years under this subsection to hear such cases in a timely manner.

“(2) INCREASED FINANCIAL SUPPORT.—In addition to any amounts otherwise appropriated, there are authorized to be appropriated (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) to the Secretary to increase the number of administrative law judges under paragraph (1) and to improve education and training opportunities for such judges and their staffs, \$5,000,000 for fiscal year 2003 and such sums as are necessary for fiscal year 2004 and each subsequent fiscal year.”.

1 (b) PROCESS FOR EXPEDITED ACCESS TO JUDICIAL
2 REVIEW.—

3 (1) IN GENERAL.—Section 1869(b) (42 U.S.C.
4 1395ff(b)) as amended by Medicare, Medicaid, and
5 SCHIP Benefits Improvement and Protection Act of
6 2000 (114 Stat. 2763A–534), as enacted into law by
7 section 1(a)(6) of Public Law 106–554, is
8 amended—

9 (A) in paragraph (1)(A), by inserting “,
10 subject to paragraph (2),” before “to judicial
11 review of the Secretary’s final decision”; and

12 (B) by adding at the end the following new
13 paragraph:

14 “(2) EXPEDITED ACCESS TO JUDICIAL RE-
15 VIEW.—

16 “(A) IN GENERAL.—The Secretary shall
17 establish a process under which a provider of
18 service or supplier that furnishes an item or
19 service or a beneficiary who has filed an appeal
20 under paragraph (1) (other than an appeal filed
21 under paragraph (1)(F)) may obtain access to
22 judicial review when a review panel (described
23 in subparagraph (D)), on its own motion or at
24 the request of the appellant, determines that it
25 does not have the authority to decide the ques-

tion of law or regulation relevant to the matters in controversy and that there is no material issue of fact in dispute. The appellant may make such request only once with respect to a question of law or regulation in a case of an appeal.

“(B) PROMPT DETERMINATIONS.—If, after or coincident with appropriately filing a request for an administrative hearing, the appellant requests a determination by the appropriate review panel that no review panel has the authority to decide the question of law or regulations relevant to the matters in controversy and that there is no material issue of fact in dispute and if such request is accompanied by the documents and materials as the appropriate review panel shall require for purposes of making such determination, such review panel shall make a determination on the request in writing within 60 days after the date such review panel receives the request and such accompanying documents and materials. Such a determination by such review panel shall be considered a final decision and not subject to review by the Secretary.

1 “(C) ACCESS TO JUDICIAL REVIEW.—

2 “(i) IN GENERAL.—If the appropriate
3 review panel—

4 “(I) determines that there are no
5 material issues of fact in dispute and
6 that the only issue is one of law or
7 regulation that no review panel has
8 the authority to decide; or

9 “(II) fails to make such deter-
10 mination within the period provided
11 under subparagraph (B);

12 then the appellant may bring a civil action
13 as described in this subparagraph.

14 “(ii) DEADLINE FOR FILING.—Such
15 action shall be filed, in the case described
16 in—

17 “(I) clause (i)(I), within 60 days
18 of date of the determination described
19 in such subparagraph; or

20 “(II) clause (i)(II), within 60
21 days of the end of the period provided
22 under subparagraph (B) for the deter-
23 mination.

24 “(iii) VENUE.—Such action shall be
25 brought in the district court of the United

1 States for the judicial district in which the
2 appellant is located (or, in the case of an
3 action brought jointly by more than one
4 applicant, the judicial district in which the
5 greatest number of applicants are located)
6 or in the district court for the District of
7 Columbia.

8 “(iv) INTEREST ON AMOUNTS IN CON-
9 TROVERSY.—Where a provider of services
10 or supplier seeks judicial review pursuant
11 to this paragraph, the amount in con-
12 troversy shall be subject to annual interest
13 beginning on the first day of the first
14 month beginning after the 60-day period
15 as determined pursuant to clause (ii) and
16 equal to the rate of interest on obligations
17 issued for purchase by the Federal Hos-
18 pital Insurance Trust Fund for the month
19 in which the civil action authorized under
20 this paragraph is commenced, to be award-
21 ed by the reviewing court in favor of the
22 prevailing party. No interest awarded pur-
23 suant to the preceding sentence shall be
24 deemed income or cost for the purposes of

1 determining reimbursement due providers
 2 of services or suppliers under this Act.

3 “(D) REVIEW PANELS.—For purposes of
 4 this subsection, a ‘review panel’ is an adminis-
 5 trative law judge, the Departmental Appeals
 6 Board, a qualified independent contractor (as
 7 defined in subsection (c)(2)), or an entity des-
 8 ignated by the Secretary for purposes of mak-
 9 ing determinations under this paragraph.”.

10 (2) EFFECTIVE DATE.—The amendment made
 11 by paragraph (1) shall apply to appeals filed on or
 12 after October 1, 2002.

13 (c) REQUIRING FULL AND EARLY PRESENTATION OF
 14 EVIDENCE.—

15 (1) IN GENERAL.—Section 1869(b) (42 U.S.C.
 16 1395ff(b)), as amended by Medicare, Medicaid, and
 17 SCHIP Benefits Improvement and Protection Act of
 18 2000 (114 Stat. 2763A–534), as enacted into law by
 19 section 1(a)(6) of Public Law 106–554, and as
 20 amended by subsection (b), is further amended by
 21 adding at the end the following new paragraph:

22 “(3) REQUIRING FULL AND EARLY PRESEN-
 23 TATION OF EVIDENCE BY PROVIDERS.—A provider
 24 of services or supplier may not introduce evidence in
 25 any appeal under this section that was not presented

1 at the first external hearing or appeal at which it
 2 could be introduced under this section, unless there
 3 is good cause which precluded the introduction of
 4 such evidence at a previous hearing or appeal.”.

5 (2) EFFECTIVE DATE.—The amendment made
 6 by paragraph (1) shall take effect on October 1,
 7 2002.

8 (d) PROVIDER APPEALS ON BEHALF OF DECEASED
 9 BENEFICIARIES.—

10 (1) IN GENERAL.—Section 1869(b)(1)(C) (42
 11 U.S.C. 1395ff(b)(1)(C)), as amended by Medicare,
 12 Medicaid, and SCHIP Benefits Improvement and
 13 Protection Act of 2000 (114 Stat. 2763A–534), as
 14 enacted into law by section 1(a)(6) of Public Law
 15 106–554, is amended by adding at the end the fol-
 16 lowing: “The Secretary shall establish a process
 17 under which, if such an individual is deceased, the
 18 individual is deemed to have provided written con-
 19 sent to the assignment of the individual’s right of
 20 appeal under this section to the provider of services
 21 or supplier of the item or service involved, so long
 22 as the estate of the individual, and the individual’s
 23 family and heirs, are not liable for paying for the
 24 item or service and are not liable for any increased
 25 coinsurance or deductible amounts resulting from

1 any decision increasing the reimbursement amount
 2 for the provider of services or supplier.”.

3 (2) EFFECTIVE DATE.—Notwithstanding sec-
 4 tion 521(d) of the Medicare, Medicaid, and SCHIP
 5 Benefits Improvement and Protection Act of 2000,
 6 as enacted into law by section 1(a)(6) of Public Law
 7 106–554, the amendment made by paragraph (1)
 8 shall take effect on the date of the enactment of this
 9 Act.

10 **SEC. 9. RECOVERY OF OVERPAYMENTS AND PREPAYMENT**
 11 **REVIEW; ENROLLMENT OF PROVIDERS.**

12 (a) RECOVERY OF OVERPAYMENTS AND PREPAY-
 13 MENT REVIEW.—Section 1893 (42 U.S.C. 1395ddd) is
 14 amended by adding at the end the following new sub-
 15 sections:

16 “(f) RECOVERY OF OVERPAYMENTS AND PREPAY-
 17 MENT REVIEW.—

18 “(1) USE OF REPAYMENT PLANS.—

19 “(A) IN GENERAL.—If the repayment,
 20 within 30 days by a provider of services, physi-
 21 cian, practitioner, or other supplier, of an over-
 22 payment under this title would constitute a
 23 hardship (as defined in subparagraph (B)), sub-
 24 ject to subparagraph (C), the Secretary shall
 25 enter into a plan (which meets terms and condi-

1 tions determined to be appropriate by the Sec-
2 retary) with the provider of services, physician,
3 practitioner, or supplier for the offset or repay-
4 ment of such overpayment over a period of not
5 longer than 3 years. Interest shall accrue on the
6 balance through the period of repayment.

7 “(B) HARDSHIP.—

8 “(i) IN GENERAL.—For purposes of
9 subparagraph (A), the repayment of an
10 overpayment (or overpayments) within 30
11 days is deemed to constitute a hardship
12 if—

13 “(I) in the case of a provider of
14 services that files cost reports, the ag-
15 gregate amount of the overpayments
16 exceeds 10 percent of the amount paid
17 under this title to the provider of
18 services for the cost reporting period
19 covered by the most recently sub-
20 mitted cost report; or

21 “(II) in the case of another pro-
22 vider of services, physician, practi-
23 tioner, or supplier, the aggregate
24 amount of the overpayments exceeds
25 10 percent of the amount paid under

1 this title to the provider of services or
2 supplier for the previous calendar
3 year.

4 “(ii) RULE OF APPLICATION.—The
5 Secretary shall establish rules for the ap-
6 plication of this subparagraph in the case
7 of a provider of services, physician, practi-
8 tioner, or supplier that was not paid under
9 this title during the previous year or was
10 paid under this title only during a portion
11 of that year.

12 “(iii) TREATMENT OF PREVIOUS
13 OVERPAYMENTS.—If a provider of services,
14 physician, practitioner, or supplier has en-
15 tered into a repayment plan under sub-
16 paragraph (A) with respect to a specific
17 overpayment amount, such payment
18 amount shall not be taken into account
19 under clause (i) with respect to subsequent
20 overpayment amounts.

21 “(C) EXCEPTIONS.—Subparagraph (A)
22 shall not apply if the Secretary has reason to
23 suspect that the provider of services, physician,
24 practitioner, or supplier may file for bankruptcy
25 or otherwise cease to do business or if there is

1 an indication of fraud or abuse committed
2 against the program.

3 “(D) IMMEDIATE COLLECTION IF VIOLA-
4 TION OF REPAYMENT PLAN.—If a provider of
5 services, physician, practitioner, or supplier fails
6 to make a payment in accordance with a repay-
7 ment plan under this paragraph, the Secretary
8 may immediately seek to offset or otherwise re-
9 cover the total balance outstanding (including
10 applicable interest) under the repayment plan.

11 “(2) LIMITATION ON RECOUPMENT UNTIL RE-
12 CONSIDERATION EXERCISED.—

13 “(A) IN GENERAL.—In the case of a pro-
14 vider of services, physician, practitioner, or sup-
15 plier that is determined to have received an
16 overpayment under this title and that seeks a
17 reconsideration of such determination under
18 section 1869(b)(1), the Secretary may not take
19 any action (or authorize any other person, in-
20 cluding any medicare contractor, as defined in
21 paragraph (9)) to recoup the overpayment until
22 the date the decision on the reconsideration has
23 been rendered.

24 “(B) COLLECTION WITH INTEREST.—Inso-
25 far as the determination on such appeal is

1 against the provider of services, physician, prac-
 2 titioner, or supplier, interest on the overpay-
 3 ment shall accrue on and after the date of the
 4 original notice of overpayment. Insofar as such
 5 determination against the provider of services,
 6 physician, practitioner, or supplier is later re-
 7 versed, the Secretary shall provide for repay-
 8 ment of the amount recouped plus interest at
 9 the same rate as would apply under the pre-
 10 vious sentence for the period in which the
 11 amount was recouped.

12 “(3) STANDARDIZATION OF RANDOM PREPAY-
 13 MENT REVIEW.—

14 “(A) IN GENERAL.—A medicare contractor
 15 may conduct random prepayment review only to
 16 develop a contractor-wide or program-wide
 17 claims payment error rates.

18 “(B) CONSTRUCTION.—Nothing in sub-
 19 paragraph (A) shall be construed as preventing
 20 the denial of payments for claims actually re-
 21 viewed under a random prepayment review.

22 “(4) LIMITATION ON USE OF EXTRAPO-
 23 LATION.—A medicare contractor may not use ex-
 24 trapolation to determine overpayment amounts to be

1 recovered by recoupment, offset, or otherwise
 2 unless—

3 “(A) there is a sustained or high level of
 4 payment error (as defined by the Secretary); or

5 “(B) documented educational intervention
 6 has failed to correct the payment error (as de-
 7 termined by the Secretary).

8 “(5) PROVISION OF SUPPORTING DOCUMENTA-
 9 TION.—In the case of a provider of services, physi-
 10 cian, practitioner, or supplier with respect to which
 11 amounts were previously overpaid, a medicare con-
 12 tractor may request the periodic production of
 13 records or supporting documentation for a limited
 14 sample of submitted claims to ensure that the pre-
 15 vious practice is not continuing.

16 “(6) CONSENT SETTLEMENT REFORMS.—

17 “(A) IN GENERAL.—The Secretary may
 18 use a consent settlement (as defined in sub-
 19 paragraph (D)) to settle a projected overpay-
 20 ment.

21 “(B) OPPORTUNITY TO SUBMIT ADDI-
 22 TIONAL INFORMATION BEFORE CONSENT SET-
 23 TLEMENT OFFER.—Before offering a provider
 24 of services, physician, practitioner, or supplier a
 25 consent settlement, the Secretary shall—

1 “(i) communicate to the provider of
2 services, physician, practitioner, or supplier
3 in a non-threatening manner that, based
4 on a review of the medical records re-
5 quested by the Secretary, a preliminary in-
6 dication appears that there would be an
7 overpayment; and

8 “(ii) provide for a 45-day period dur-
9 ing which the provider of services, physi-
10 cian, practitioner, or supplier may furnish
11 additional information concerning the med-
12 ical records for the claims that had been
13 reviewed.

14 “(C) CONSENT SETTLEMENT OFFER.—The
15 Secretary shall review any additional informa-
16 tion furnished by the provider of services, physi-
17 cian, practitioner, or supplier under subpara-
18 graph (B)(ii). Taking into consideration such
19 information, the Secretary shall determine if
20 there still appears to be an overpayment. If so,
21 the Secretary—

22 “(i) shall provide notice of such deter-
23 mination to the provider of services, physi-
24 cian, practitioner, or supplier, including an

1 explanation of the reason for such deter-
 2 mination; and

3 “(ii) in order to resolve the overpay-
 4 ment, may offer the provider of services,
 5 physician, practitioner, or supplier—

6 “(I) the opportunity for a statis-
 7 tically valid random sample; or

8 “(II) a consent settlement.

9 The opportunity provided under clause (ii)(I)
 10 does not waive any appeal rights with respect to
 11 the alleged overpayment involved.

12 “(D) CONSENT SETTLEMENT DEFINED.—

13 For purposes of this paragraph, the term ‘con-
 14 sent settlement’ means an agreement between
 15 the Secretary and a provider of services, physi-
 16 cian, practitioner, or supplier whereby both par-
 17 ties agree to settle a projected overpayment
 18 based on less than a statistically valid sample of
 19 claims and the provider of services, physician,
 20 practitioner, or supplier agrees not to appeal
 21 the claims involved.

22 “(7) LIMITATIONS ON NON-RANDOM PREPAY-
 23 MENT REVIEW.—

24 “(A) LIMITATION ON INITIATION OF
 25 NON-RANDOM PREPAYMENT REVIEW.—A

1 medicare contractor may not initiate non-
2 random prepayment review of a provider of
3 services, physician, practitioner, or supplier
4 based on the initial identification by that
5 provider of services, physician, practitioner,
6 or supplier of an improper billing practice
7 unless there is a sustained or high level of
8 payment error (as defined in paragraph
9 (4)(A)).

10 “(B) TERMINATION OF NON-RANDOM
11 PREPAYMENT REVIEW.—The Secretary
12 shall issue regulations relating to the ter-
13 mination, including termination dates, of
14 non-random prepayment review. Such reg-
15 ulations may vary such a termination date
16 based upon the differences in the cir-
17 cumstances triggering prepayment review.

18 “(8) PAYMENT AUDITS

19 “(A) WRITTEN NOTICE FOR POST-PAY-
20 MENT AUDITS.—Subject to subparagraph (C), if
21 a medicare contractor decides to conduct a
22 post-payment audit of a provider of services,
23 physician, practitioner, or supplier under this
24 title, the contractor shall provide the provider of
25 services, physician, practitioner, or supplier

1 with written notice of the intent to conduct
2 such an audit.

3 “(B) EXPLANATION OF FINDINGS FOR ALL
4 AUDITS.—Subject to subparagraph (C), if a
5 medicare contractor audits a provider of serv-
6 ices, physician, practitioner, or supplier under
7 this title, the contractor shall—

8 “(i) give the provider of services, phy-
9 sician, practitioner, or supplier a full re-
10 view and explanation of the findings of the
11 audit in a manner that is understandable
12 to the provider of services, physician, prac-
13 titioner, or supplier and permits the devel-
14 opment of an appropriate corrective action
15 plan;

16 “(ii) inform the provider of services,
17 physician, practitioner, or supplier of the
18 appeal rights under this title; and

19 “(iii) give the provider of services,
20 physician, practitioner, or supplier an op-
21 portunity to provide additional information
22 to the contractor.

23 “(C) EXCEPTION.—Subparagraphs (A)
24 and (B) shall not apply if the provision of no-
25 tice or findings would compromise pending law

1 enforcement activities or reveal findings of law
2 enforcement-related audits.

3 “(9) DEFINITIONS.—For purposes of this sub-
4 section:

5 “(A) MEDICARE CONTRACTOR.—The term
6 ‘medicare contractor’ has the meaning given
7 such term in section 1889(f).

8 “(B) RANDOM PREPAYMENT REVIEW.—
9 The term ‘random prepayment review’ means a
10 demand for the production of records or docu-
11 mentation absent cause with respect to a claim.

12 “(g) NOTICE OF OVER-UTILIZATION OF CODES.—
13 The Secretary shall establish a process under which the
14 Secretary provides for notice to classes of providers of
15 services, physicians, practitioners, and suppliers served by
16 the contractor in cases in which the contractor has identi-
17 fied that particular billing codes may be overutilized by
18 that class of providers of services, physicians, practi-
19 tioners, or suppliers under the programs under this title
20 (or provisions of title XI insofar as they relate to such
21 programs).”.

22 (b) PROVIDER ENROLLMENT PROCESS; RIGHT OF
23 APPEAL.—

24 (1) IN GENERAL.—Section 1866 (42 U.S.C.
25 1395cc) is amended—

1 (A) by adding at the end of the heading
 2 the following: “; ENROLLMENT PROCESSES”;
 3 and

4 (B) by adding at the end the following new
 5 subsection:

6 “(j) ENROLLMENT PROCESS FOR PROVIDERS OF
 7 SERVICES, PHYSICIANS, PRACTITIONERS, AND SUP-
 8 PLIERS.—

9 “(1) IN GENERAL.—The Secretary shall estab-
 10 lish by regulation a process for the enrollment of
 11 providers of services, physicians, practitioners, and
 12 suppliers under this title.

13 “(2) APPEAL PROCESS.—Such process shall
 14 provide—

15 “(A) a method by which providers of serv-
 16 ices, physicians, practitioners, and suppliers
 17 whose application to enroll (or, if applicable, to
 18 renew enrollment) are denied are provided a
 19 mechanism to appeal such denial; and

20 “(B) prompt deadlines for actions on ap-
 21 plications for enrollment (and, if applicable, re-
 22 newal of enrollment) and for consideration of
 23 appeals.”.

24 (2) EFFECTIVE DATE.—The Secretary of
 25 Health and Human Services shall provide for the es-

1 tablishment of the enrollment and appeal process
 2 under the amendment made by paragraph (1) within
 3 6 months after the date of the enactment of this
 4 Act.

5 (c) PROCESS FOR CORRECTION OF MINOR ERRORS
 6 AND OMISSIONS ON CLAIMS WITHOUT PURSUING AP-
 7 PEALS PROCESS.—The Secretary of Health and Human
 8 Services shall develop, in consultation with appropriate
 9 medicare contractors (as defined in section 1889(f) of the
 10 Social Security Act, as inserted by section 5(f)(1)) and
 11 representatives of providers of services, physicians, practi-
 12 tioners, and suppliers, a process whereby, in the case of
 13 minor errors or omissions that are detected in the submis-
 14 sion of claims under the programs under title XVIII of
 15 such Act, a provider of services, physician, practitioner,
 16 or supplier is given an opportunity to correct such an error
 17 or omission without the need to initiate an appeal. Such
 18 process may include the ability to resubmit corrected
 19 claims.

20 **SEC. 10. BENEFICIARY OUTREACH DEMONSTRATION PRO-**
 21 **GRAM.**

22 (a) IN GENERAL.—The Secretary of Health and
 23 Human Services shall establish a demonstration program
 24 (in this section referred to as the “demonstration pro-
 25 gram”) under which medicare specialists employed by the

1 Department of Health and Human Services provide advice
2 and assistance to medicare beneficiaries at the location of
3 existing local offices of the Social Security Administration.

4 (b) LOCATIONS.—

5 (1) IN GENERAL.—The demonstration program
6 shall be conducted in at least 6 offices or areas.
7 Subject to paragraph (2), in selecting such offices
8 and areas, the Secretary shall provide preference for
9 offices with a high volume of visits by medicare
10 beneficiaries.

11 (2) ASSISTANCE FOR RURAL BENEFICIARIES.—
12 The Secretary shall provide for the selection of at
13 least 2 rural areas to participate in the demonstra-
14 tion program. In conducting the demonstration pro-
15 gram in such rural areas, the Secretary shall provide
16 for medicare specialists to travel among local offices
17 in a rural area on a scheduled basis.

18 (c) DURATION.—The demonstration program shall be
19 conducted over a 3-year period.

20 (d) EVALUATION AND REPORT.—

21 (1) EVALUATION.—The Secretary shall provide
22 for an evaluation of the demonstration program.
23 Such evaluation shall include an analysis of—

1 (A) utilization of, and beneficiary satisfac-
 2 tion with, the assistance provided under the
 3 program; and

4 (B) the cost-effectiveness of providing ben-
 5 eficiary assistance through out-stationing medi-
 6 care specialists at local social security offices.

7 (2) REPORT.—The Secretary shall submit to
 8 Congress a report on such evaluation and shall in-
 9 clude in such report recommendations regarding the
 10 feasibility of permanently out-stationing medical spe-
 11 cialists at local social security offices.

12 **SEC. 11. POLICY DEVELOPMENT REGARDING EVALUATION**
 13 **AND MANAGEMENT (E & M) DOCUMENTATION**
 14 **GUIDELINES.**

15 (a) IN GENERAL.—The Secretary of Health and
 16 Human Services may not implement any documentation
 17 guidelines for evaluation and management physician serv-
 18 ices under the title XVIII of the Social Security Act on
 19 or after the date of the enactment of this Act unless the
 20 Secretary—

21 (1) has developed the guidelines in collaboration
 22 with practicing physicians and provided for an as-
 23 sessment of the proposed guidelines by the physician
 24 community;

1 (2) has established a plan that contains specific
 2 goals, including a schedule, for improving the use of
 3 such guidelines;

4 (3) has conducted appropriate and representa-
 5 tive pilot projects under subsection (b) to test modi-
 6 fications to the evaluation and management docu-
 7 mentation guidelines; and

8 (4) finds that the objectives described in sub-
 9 section (c) will be met in the implementation of such
 10 guidelines.

11 The Secretary may make changes to the manner in which
 12 existing evaluation and management documentation guide-
 13 lines are implemented to reduce paperwork burdens on
 14 physicians.

15 (b) PILOT PROJECTS TO TEST EVALUATION AND
 16 MANAGEMENT DOCUMENTATION GUIDELINES.—

17 (1) LENGTH AND CONSULTATION.—Each pilot
 18 project under this subsection shall—

19 (A) be of sufficient length to allow for pre-
 20 paratory physician and medicare contractor
 21 education, analysis, and use and assessment of
 22 potential evaluation and management guide-
 23 lines; and

24 (B) be conducted, in development and
 25 throughout the planning and operational stages

1 of the project, in consultation with practicing
2 physicians.

3 (2) RANGE OF PILOT PROJECTS.—Of the pilot
4 projects conducted under this subsection—

5 (A) at least one shall focus on a peer re-
6 view method by physicians (not employed by a
7 medicare contractor) which evaluates medical
8 record information for claims submitted by phy-
9 sicians identified as statistical outliers relative
10 to definitions published in the Current Proce-
11 dures Terminology (CPT) code book of the
12 American Medical Association;

13 (B) at least one shall be conducted for
14 services furnished in a rural area and at least
15 one for services furnished outside such an area;
16 and

17 (C) at least one shall be conducted in a
18 setting where physicians bill under physicians
19 services in teaching settings and at one shall be
20 conducted in a setting other than a teaching
21 setting.

22 (3) BANNING OF TARGETING OF PILOT
23 PROJECT PARTICIPANTS.—Data collected under this
24 subsection shall not be used as the basis for overpay-
25 ment demands or post-payment audits.

1 (4) STUDY OF IMPACT.—Each pilot project
2 shall examine the effect of the modified evaluation
3 and management documentation guidelines on—

4 (A) different types of physician practices,
5 including those with fewer than 10 full-time-
6 equivalent employees (including physicians);
7 and

8 (B) the costs of physician compliance, in-
9 cluding education, implementation, auditing,
10 and monitoring.

11 (c) OBJECTIVES FOR EVALUATION AND MANAGE-
12 MENT GUIDELINES.—The objectives for modified evalua-
13 tion and management documentation guidelines developed
14 by the Secretary shall be to—

15 (1) enhance clinically relevant documentation
16 needed to code accurately and assess coding levels
17 accurately;

18 (2) decrease the level of non-clinically pertinent
19 and burdensome documentation time and content in
20 the physician's medical record;

21 (3) increase accuracy by reviewers; and

22 (4) educate both physicians and reviewers.

23 (d) STUDY OF SIMPLER, ALTERNATIVE SYSTEMS OF
24 DOCUMENTATION FOR PHYSICIAN CLAIMS.—

1 (1) STUDY.—The Secretary of Health and
2 Human Services shall carry out a study of the mat-
3 ters described in paragraph (2).

4 (2) MATTERS DESCRIBED.—The matters re-
5 ferred to in paragraph (1) are—

6 (A) the development of a simpler, alter-
7 native system of requirements for documenta-
8 tion accompanying claims for evaluation and
9 management physician services for which pay-
10 ment is made under title XVIII of the Social
11 Security Act; and

12 (B) consideration of systems other than
13 current coding and documentation requirements
14 for payment for such physician services.

15 (3) CONSULTATION WITH PRACTICING PHYSI-
16 CIANS.—In designing and carrying out the study
17 under paragraph (1), the Secretary shall consult
18 with practicing physicians, including physicians who
19 are part of group practices.

20 (4) APPLICATION OF HIPAA UNIFORM CODING
21 REQUIREMENTS.—In developing an alternative sys-
22 tem under paragraph (2), the Secretary shall con-
23 sider requirements of administrative simplification
24 under part C of title XI of the Social Security Act.

1 (5) REPORT TO CONGRESS.—The Secretary
2 shall submit to Congress a report on the results of
3 the study conducted under paragraph (1).

4 (e) DEFINITIONS.—In this section—

5 (1) the term “rural area” has the meaning
6 given that term in section 1886(d)(2)(D) of the So-
7 cial Security Act, 42 U.S.C. 1395ww(d)(2)(D); and

8 (2) the term “teaching settings” are those set-
9 tings described in section 415.150 of title 42, Code
10 of Federal Regulations.

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